**COMMUNITY SPEECH AND LANGUAGE THERAPY: FEEDING REFERRAL FORM**

(Referral for babies/children where there is concern about safety of swallow and/or oral-motor feeding difficulties, or children under 18 months with sensory-aversive feeding issues. See SLT Dysphagia Thresholds document for further info.)

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **DETAILS OF CHILD BEING REFERRED** | | | | | | | | | | | | | | | | | | | | | | | | | |
| **FIRST NAME:** | |  | | | | | | | | | | | | | | | **SURNAME:** | | | |  | | | | |
| **NHS NO.** |  | | | | | | | | | | | | **D.O.B** | | |  | | | | | **GENDER** | | | **M / F** | |
| **ADDRESS INC. POSTCODE:** | | | | |  | | | | | | | | | | | | | | | | | | | | |
| **PHONE NUMBERS:** | | | | | **HOME:** | | | | | | |  | | | | | | **MOBILE:** | | | |  | | | |
| **PARENT/CARER NAMES:** | | | | | | | |  | | | | | | | | | | **RELATIONSHIP:** | | | |  | | | |
| **GP NAME/PRACTICE:** | | | | | | | |  | | | | | | | | | | | | | | | | | |
| **PRACTICE ADDRESS/PHONE NO:** | | | | | | | | |  | | | | | | | | | | | | | | | | |
| **HV NAME:** | |  | | | | | | | | | | | | | | | | | | | | | | | |
| **HV BASE:** | |  | | | | | | | | | | | | | | | | | **PHONE NUMBER:** | | | |  | | |
| **NAMES/CONTACTS OF OTHER INVOLVED PROFESSIONALS/AGENCIES:** | | | | | | | | | | | | | |  | | | | | | | | | | | |
| **HAS CHILD BEEN KNOWN TO SLT IN PAST?** | | | | | |  | | | | | | | | | | | | | | | | | | | |
| **DETAILS OF ANY MEDICAL ISSUES:** | | | | | | | | | | |  | | | | | | | | | | | | | | |
| **DETAILS OF CURRENT MEDICATION:** | | | | | | | | | | |  | | | | | | | | | | | | | | |
| **ARE THERE CONCERNS ABOUT GROWTH?** | | | | | | | | | | | | | | |  | | | | | | | | | | |
| **PREFERRED VENUE FOR APPOINTMENT:** | | | | **HOME** | | | | | | | **NURSERY/SCHOOL**  **(GIVE DETAILS) →** | | | | | | |  | | | | | | | |
| **LANGUAGES SPOKEN AT HOME:** | | | | | | | | | |  | | | | | | | | | | | | | | | |
| **INTERPRETER REQUIRED?** | | | **YES** | | | | **NO** | | | **IF YES, PLEASE INCLUDE SPECIFIC REQUIREMENTS EG GENDER OF INTERPRETER, LANGUAGE/DIALECT:** | | | | | | | | | |  | | | | | |
| **ARE THERE ANY SAFEGUARDING CONCERNS?**  **IF YES, SLT WILL CONTACT REFERRER.** | | | | | | | | | | | | | | | | **YES** | | | | **NO** | | | | | **NOT KNOWN** |
| **REASON FOR FEEDING REFERRAL, AND ADVICE GIVEN SO FAR:** | | | | | | |  | | | | | | | | | | | | | | | | | | |
| **PARENTAL VIEWS:** | | | | | | |  | | | | | | | | | | | | | | | | | | |

|  |  |
| --- | --- |
| **DETAILS OF REFERRER** | |
| NAME |  |
| DESIGNATION |  |
| BASE, CONTACT No & EMAIL: |  |
| SIGNED |  |
| DATE |  |

|  |  |
| --- | --- |
| **DETAILS OF DOCTOR CONSENT – THIS IS ESSENTIAL TO PROCESS REFERRAL. (CONSENT CAN BE VERBAL, eg, on phone, from eg GP or Paediatrician)** | |
| NAME OF DOCTOR |  |
| ROLE |  |
| BASE & CONTACT DETAILS |  |
| DATE CONSENT OBTAINED |  |

**WE AIM TO SEE NEW FEEDING REFERRALS WITHIN 4 WEEKS OF THE SLT RECEIVING THE REFERRAL. ALL PARTS OF THE FORM MUST BE COMPLETED IN ORDER TO PROCESS THE REFERRAL. IF IT IS NOT FULLY COMPLETED IT WILL BE RETURNED TO THE REFERRER.**

**PLEASE RETURN TO: SLT Admin, Leeds Community Healthcare, Building 3, White Rose Park, Millshaw Park Lane, Leeds, LS11 0DL**

**TEL: SLT Secretaries on 0113 8433650**

**IF YOU ARE UNSURE WHETHER THIS REFERRAL IS APPROPRIATE, please call 0113 8432760 to discuss with Liz Franklin (Clinical Lead) or email liz.franklin@nhs.net**